Seena Perumal Carrington

-- research and issuing reports of this caliber and this nature that really get at the heart of some of the challenges confronting the delivery system. Attorney General, as I mentioned to you on your way in, you are fortunate to have a remarkable team of individuals working with you who have just been so helpful in this process and are definitely our partners -- by all stretch of the imagination -- are our partners and our friends and we can't thank them enough. So it's with pleasure that I get to introduce Attorney General, Martha Coakley, to walk through the AG's findings on healthcare cost drivers.

Martha Coakley

Thank you. Thank you, Seena. Thank you very much. It's been an interesting morning, although a very serious morning. I noted we got through the whole morning without any mention of the Bruins or Whitey Bulger. So I don't know if that's a

success or not and I want to go through just a brief introduction to some of the findings that we made in our report this year, but I was reminded of a cartoon I saw this week in the *New Yorker*. There's a doctor sitting behind his desk with a patient in front of him and the doctor says, "I'm not sure what you have is serious, but I'm going to bill you for it as if it is, just in case," or something to that effect. So I thought it was relevant to our hearings today about cost containment. I'm pleased to be able to present our office's examination of healthcare cost trends and cost drivers. I particularly want to thank Governor Patrick, Senate President Murray, Speaker DeLeo, Chairman Moore and Steve Walsh, who is here this morning, as well as Representative Sanchez and Inspector General Sullivan, who you heard from, for their commitment to addressing healthcare costs. And thanks also, obviously, to Secretary Bigby, Commissioner Murphy, to Commissioner Auerbach, who is here, and especially to Commissioner Carrington for your work in coordinating these hearings, which are an important piece of what we continue to do. These hearings provide and important opportunity to address the significant healthcare cost that we face in the Commonwealth and as the Commonwealth. We've noted in our report -- and I know you've heard this -- that health spending in Massachusetts, with a 10% increase in commercial

spending in 2009, continues to outpace growth in key economic indicators, such as wages and inflation. As we've heard this morning, uncontrolled increases in health expenses affect adversely our businesses, our consumers, as well as the Commonwealth and I believe that they threaten the historic gains we've made as a state in universal access, as well as our ability as a Commonwealth to recover from this economic down turn. We need consumers, employers, health plan providers and policy makers engaged in the important task before us of controlling the soaring rate of healthcare and improving how we deliver care to patients. Addressing healthcare cost while preserving quality and access is a priority for our office across many divisions, including our consumer protection division, our enforcement in healthcare, our antitrust and charities oversight and our Medicaid fraud prosecution. In particular, I have used our examination authority from the legislature to bring transparency and accountability to the complex system of healthcare delivery and payment, looking for data and metrics of cost, quality and efficiency. As the current wisdom goes, you can pick two and we'd be all set. The problem is that we want all three. Assessing these metrics is critical because they provide a building block for change and if

we don’t define them, we can’t measure them, we can’t move forward on containing cost in healthcare.

In our report that we released last year, we documented significant dysfunction in the commercial healthcare market, finding wide disparities in prices unrelated to quality or other value based factors. We also showed the significant role that provider price increases play in driving up healthcare costs. In the report that we’ve submitted this year, in this hearing, we examine two key questions that we believe we have to continue to address as we seek to improve the efficiency and the effectiveness of our healthcare system. First, how do we best improve market function? The healthcare market, like any competitive market, must be responsive to the purchasers. In this market, both employers and consumers must have an incentive and the information necessary to make more efficient and effective use of healthcare, as well as purchase of healthcare products. The system does not do that at the present time. Second, how do we improve care coordination? Care coordination functions best and the outcomes are the best when patients, providers and insurers agree on an approach to improving care and work in concert with one another. So this year we examined first whether global payments have resulted in lower total

medical expenses, whether medical spending on patients differs depending on patient income level. Third, how a variety of organized provider groups of different sizes and structures provide coordinated patient care and managed risk. Our goal for these cost trend examinations is not to suggest who is right or wrong, but rather to both hold a mirror to the current system as well we shine a light on that market using the best data and information available so that we can further inform future discussions on care coordination, payment reform and insurance product design. We greatly appreciate the courtesy and the coordination of health insurers and providers who cooperated with us and provided information for this examination and we continue to look forward, as everybody has mentioned here today, continuing our collective efforts. I'm going to go quickly through our six key findings and then for further explanation, I'll turn to Assistant Attorney General Susan Brown, who's with me here today. You're also going to hear from Bela Gorman who did some expert work on our report and I assume, if time, then for questions. I assume [inaudible; break in audio].

First, there's a wide variation in the payments made by health insurers to providers that's not adequately explained by differences in quality of care. Not new news based somewhat on

findings last year, but we found that again and it remains a key finding. Two, globally paid providers do not have consistently lower, total medical expenses and Susan will explain. We've looked going back over five years to see if global payments alone could reduce medical expenses; TME's: total medical expenses. Three, total medical spending is, on average, higher for the care of health plan members with higher incomes. We can talk a little bit more about that finding. I think it has implications going forward as we look at this system. Four, tiered and limited network products have increased consumer engagement in value-based purchasing decisions and you heard about that this morning. We think this piece is really important going forward in terms of tiered and limited network products. Five, preferred provider organizations, or PPO health plans, unlike health maintenance organizations, HMOs, create significant impediments for providers to coordinate patient care because those plans, the PPO plans, are not designed around primary care providers who have the information and the authority necessary to coordinate the provision of healthcare effectively. Six, healthcare provider organizations designed around primary care can coordinate care effectively through a variety of organizational models; two, provided the appropriate data and resources and three, while global payments may

encourage care coordination, they pose significant challenges. So the issue around effectively designing primary care remains a key issue for us, going forward, keeping cost down and healthcare quality and access up.

Examination report; is this you, Susan? Yeah. So let me go back for one second. We indicate, in our findings, a little more. Susan is going to give a little more depth to those and also talk about some of the representations we've made and some of the things we think are implication by these findings. So it's my pleasure, now, to introduce Assistant Attorney General Susan Brown. She's going to provide an overview of the findings and after her will be Bela Gorman. She's a principal of Gorman Actuarial, who will follow with a review of the methodology used in the analysis, and our healthcare division team will present more detailed information on the analytical findings throughout the course of these hearings. I want to say thank you to them, many of whom are here. You've just done a terrific job in working all year long on this report. So, Susan?

Susan Brown

I was just told I have to get right into the mic, but I'm a little tall. So I'll do what I can and let me know if you can't hear me. Thank you, General Coakley. The Attorney General's office has statutory authority to issue subpoenas to payers and providers in Massachusetts to examine cost trends and cost drivers and we take that authority very seriously. This year we issued subpoenas to payers and providers across Massachusetts and reviewed confidential information with the goal of really understanding what it is that's driving cost in Massachusetts so that we can contribute that information to the dialogue moving forward. I just want to take a minute, again, to thank all of the payers and providers, some of whom I see represented here today, for their assistance in helping us with this examination and for all of the information and important materials that they provided to our office.

To set the stage for explaining our analysis, I want to review just a few key metrics and definitions that were important to our examination so that we're all starting from a common understanding. We focused on two measures of healthcare cost. The first is price. Price is the negotiated amount that

healthcare insurers pay to providers for the services that they render to patients. It’s important to review price information because it gives us an understanding of how much different providers are paid to care for patients for the same services. Although prices are paid on a service-by-service basis, health insurers and providers negotiate them all at once. They don’t negotiate service-by-service. So we reviewed the entire spectrum of prices that are paid from insurance companies to providers.

Another important metric that we’ve viewed this year is total medical expenses, or TME. Total medical expenses are the total cost of care associated with a patient. So, for example, if I trip leaning towards this microphone and I break my ankle, all of the cost of care associated with that will be reflected in my TME. If I go to the emergency room, if I go to physical therapy afterwards, x-rays, visiting my primary care provider, all of that will be reflected in the total medical expenses. Total medical expenses can be health status adjusted so that we can control for differences in the populations. Because TME can be health status adjusted and because it reflects the total cost of care, the price and the volume, we believe that total medical expenses are the best measure of the efficiency of providers.

Our examination also focused on how insurers reimburse providers. Generally speaking, the most common way that insurance companies pay providers is what we call a fee-for-service. Fee-for-service payment method, insurance companies pay healthcare providers for each unit, or each service, provided. Providers are reimbursed when they submit a claim to the insurance company. So really, the amount that they are paid is directly related to the volume of services that they're submitted claims for. Another type of payment method that we reviewed is called global risk payments. Under that type of global payment, instead of being paid for each unit or for each service of care, providers are instead put on a budget to cover all of the costs of care associated with their patients. So for example, an insurance company and a provider might negotiate a $400 per member, per month budget. What that means is at the end of the year, the insurance company will look at the total cost of care associated with that provider's population. If on average the total cost of care was more than $400, then that provider is going to be in what we call a deficit position. They are going to owe money back to the insurance company. If, on the other hand, the total cost of care, on average, is less than $400, then they have a surplus. They're going to get some money back from the insurance company. The thought behind global

or risk payment is that they reward providers for efficiency instead of for volume.

We also reviewed how providers deliver healthcare. To examine provider quality performance, we reviewed the best, publically available, widely accepted quality data, including hospital quality data from CMS and Mass-DAC and physician quality data from MHQP. Finally, as we review how healthcare insurers and providers work to coordinate patient care, we define care coordination as quality care that is primary care based and managed over time and across healthcare settings.

With those definitions in mind, I'd like to walk through each of the Attorney General's findings this year. First, we looked relative prices paid by health insurers to providers in their network, both to physicians and to hospitals. What we found is that there is a wide variation in the amount that health insurers pay to providers in their networks. This particular slide shows one example of prices paid by one health insurer to the physicians in their network in 2009. What this slide shows is that there is a 230% difference in the price paid by this health insurer to the lowest and highest paid physicians. So in other words, the highest paid physician group was paid more than

three times what the lowest paid physician group is paid in this particular insurer's network in 2009. When we compared these differences in price to differences in quality and performance, what we found is that the wide differences in prices paid to providers aren't adequately explained by any differences in the quality or performance of those providers.

Our examination put a particular focus on global risk contracts this year. One thing we did was examine the global risk budget that's negotiated between insurers and healthcare providers in Massachusetts. So in our earlier hypothetical, that $400 per member, per month, that global budget target amount is negotiated. What we found is that there is also significant variation in the global budgets that are negotiated between insurers and providers who are on global risk contracts. So for example, in one health insurer network in 2009, one provider who was on a global risk budget was paid about $430 per member, per month. That was their budget. Another provider, for the same year, in the same insurance network, had a budget of $275 per member, per month. Now these budgets are health status adjusted, which means that the provider who was paid about $430 per member, per month was not caring for sicker patients or for

older patients. They were just able to negotiate a richer contract, a larger budget.

Next we examined global risk contracts in the market to understand whether providers who are paid under a global risk contract have lower total medical expenses than providers who are paid on a fee-for-service basis. What this chart shows you is the total medical expenses for all of the providers in one insurer’s network in 2009. All of the providers who are paid on a global risk basis are shown here in red. If providers who have global risk budgets were more efficient than fee-for-service providers in 2009, you would expect to see those red bars really clustering towards the left, but we didn’t see that. What we found instead was that there was no consistent relationship between providers being in a global risk contract and having lower total medical expenses. It’s important to note that this is true even for providers who are in global risk contracts for more than five years. Here those providers are indicated with that yellow circle with the five plus. All of those providers have been in global risk contracts in 2009 for five or more years. Because they have mature experience in global risk contracts, we would expect any efficiencies related to that experience to be reflected in their 2009 total medical expense.

We also found that global risk contracts might pose challenges that the Commonwealth should be mindful of as we move forward with healthcare reform. First, very few providers in Massachusetts have experience with global risk contracts. Even today, as we move forward towards more global contracts, fewer than a quarter of commercial patients in Massachusetts have their care reimbursed through a global risk contract. Second, bearing risk does require significant infrastructure and resources. We found in our examination that no two providers managed risk quite the same way, but what was consistent is that all of them required significant resources in order to manage that risk. Finally, we do need to insure and protect against the possibility that risk contracts might create incentives for providers to avoid patients whose care is more difficult to manage. As part of our examination of global payments, we examined the alternative quality contract, or the AQC, that Blue Cross Blue Shield has recently introduced into the market. The AQC is a global risk model that's designed to constrain cost trends by reducing the medical claims increase over a five year period. We reviewed the AQC model to determine whether 2009 AQC provider contracts, as they were negotiated, are likely to result in cost savings as compared to non-AQC providers. What we

found is that from 2008-2009, AQC providers experienced significant increases in both their price and their total medical expenses. We were able to use some of the contract information produced by Blue Cross Blue Shield to project out the total medical expenses of AQC providers at the end of their five year contract in 2013. When we did that, what our analysis shows is that in the year 2013, AQC providers are unlikely to have lower total medical expenses than non-AQC providers.

In addition to receiving total medical expenses by provider group, this year we were also able to review total medical expense information by zip code. Using that information, we could compare, for each zip code in Massachusetts, the average total medical expenses with the average income of people who lived in that zip code. Looking at the next graph, you'll see that our examination found that total medical spending is higher for patients who live in zip codes with higher average incomes. If you look at the bar furthest to the left on this graph, it represents the lowest average total medical expenses in this particular health insurer's network. So here, $335 per member, per month. Do you see that of those zip codes with the lowest average total medical expense, roughly half of those zip codes also had the lowest average income? Conversely, if you look at the bar all the way to the right, what you see here are the zip

codes in Massachusetts with the highest average total medical expenses. Well over half of those zip codes also had the highest average income.

We were able to review this information and do this analysis because of the important information that we received through our subpoenas that will soon be made publically available through Chapter 288. This type of data should be available to guide decision makers going forward. Another way that increased transparency and may help increase healthy market functioning is through insurance product design. We reviewed various healthcare insurance products that are available to consumers in Massachusetts today and what we found is that typically those insurance products don’t reward consumers for making value-based decisions. That is, there’s no cost savings associated with patients who decide to go to high quality, low cost providers. Limited and tiered network products encourage value-based purchasing by rewarding consumers who choose more efficient providers and by shifting patient volume to high quality, low cost providers. As you heard earlier from Commissioner Murphy, the market has already started to move towards these types of products and we should continue to encourage innovative product design that rewards value-based purchasing decisions.

The second major area our examination focused on this year is how health insurers and providers work to coordinate the care of their patients. What we found is that selection of a primary care provider is essential to care coordination because primary care providers have both the information and the authority necessary to coordinate the care of their patients. Certain types of health insurance plans require that members select a primary care provider, but others do not. For example, preferred provider organization plans, or PPO plans as they are commonly known, don't require patients to select a primary care provider. As a result, they don't allow for oversight of where and how patients receive care. Physicians whose patients are in PPO type plans aren't able to coordinate the care of their patients as well as they can coordinate the care of their patients who are required to select a primary care provider. This distinction also has important implications for global risk contracting. Right now in Massachusetts, providers are only in global risk contracts for patients who are required to select a primary care physician. So in other words, no provider in Massachusetts right now is at risk for PPO patients. That's because in part, providers need to have that data and that authority in order to manage the care of their patients so that they can in turn

manage their global risk contract. Today, over 40% of the commercial membership at the three major health insurers are enrolled in PPO plans and that number is rising. If we want to encourage care coordination, then we must also continue to encourage primary care.

Finally, our examination found that providers can coordinate care regardless of their organizational structure. There's no one size fits all when it comes to providers and how they coordinate care. We reviewed provider organizations that were large, that were small, that were primary care based, that included hospitals, that didn't include hospitals; a lot of different types of organizational structures. And what we found is all of them are able to coordinate the care of their patients and they all do it in very different ways; however, one commonality is that all of them required adequate data and resources in order to coordinate that care. Care coordination requires some amount of infrastructure. Each provider group had a different type of infrastructure, but all of them had something, whether it was electronic medical records, nurse managers, disease registries; the list goes on. But resources are necessary for providers to develop those infrastructures. In addition, providers need data, especially claims data, in

order to coordinate the care of their patients. Right now in Massachusetts, providers typically only receive claims data if they are in some type of global risk budget. Otherwise, providers don't receive claims data from health insurers. We should encourage and facilitate the availability of claims data to all providers so that they can better coordinate the care of their patients. Now I'd like to introduce Bela Gorman, Principal of Gorman Actuarial to review some of the important data that we examined in our analysis this year.

Bela Gorman

Hello. My name is Bela Gorman. I am the Fellow of the Society of Actuaries and a member of the American Academy of Actuaries. Since 2005, I have been Principal of Gorman Actuarial. My primary focus over the past six years has been assisting state governments in analyzing the impact of health reform policies on the insured markets. In addition, I've assisted various insurance companies with pricing and financial forecasting. From 1999-2004, I served as Director of Actuarial Services at Harvard Pilgrim Healthcare, where I was responsible for pricing and financial forecasting and held other actuarial and

underwriting positions with other health insurers in the state. I am pleased to testify about my work on the Attorney General's examination of healthcare cost trends and cost drivers.

As you've heard this afternoon, the AGO found that there is wide variation in both fee-for-service and global payments paid by commercial health insurers to providers for similar services. Globally paid providers do not have consistently lower total medical expenses than fee-for-service providers and total medical spending is, on average, higher for the care of commercial patients from higher income zip codes. I will focus my remarks today on the financial measures of the AGO used to analyze the healthcare market and the important of timely, reliable data to enable market participants to measure, understand and improve the quality and efficiency of healthcare. In conducting its examination, the AGO reviewed three key financial measures to understand cost in the healthcare market. One, fee-for-service prices. Two, global or risk payments and three, total medical expense, or TME.

One, fee-for-service prices. Through civil investigative demands, the AGO obtained detailed information from the major health insurers on the relative payments the insurers made to Massachusetts hospitals and physician groups in each insurers

network. Like the health plans, the AGO examined relative payments in the aggregate rather than at the procedure level. In other words, the AGO compared the relative price for all services a hospital or physician group provides rather than comparing the price of any one particular service. I believe this approach more accurately reflects the way insurers and providers negotiate and set prices and resulted in valid comparisons among providers. The AGO obtained information on relative reimbursement two ways: through price relativities and payment relativities. Both measures are valid approaches of comparing relative payments made by health insurers to hospitals and physician groups. Both are well accepted measures regularly used in the industry. I do caution that because the relativities are insurer specific and calculated according to two different methods, the data should not be used to compare relativities across insurers or to determine whether one health insurer pays a provider more or less than another insurer. That said, the ranking of the relativities across insurers is directionally consistent. For each insurer, we found wide variation in payments to providers for similar services. I believe that these findings are consistent with the Division of Healthcare Finance and Policy’s findings in its preliminary reports that there is significant variation in the prices paid for the same healthcare

services. The division also found that increasing prices are largely responsible for faster growth in total healthcare spending in the commercial market. In my opinion, price is a significant driver of increases in healthcare costs and needs to be addressed in any policy solution designed to contain healthcare cost growth. Efforts to address utilization are important, but unless price trends are mitigated, cost containment efforts will not have a meaningful impact on healthcare cost trends.

Two, global risk payments. The AGO also examined payments made by the three major insurers to providers on a global or risk basis. A global payment is a per member, per month target amount negotiated between an insurer and a provider. At year end, the insurer compares that target amount or budget to the total claims cost for the patient population cared for by the provider. If claims costs for the patient population exceed the target budget, the provider owes a deficit payment to the health plan. If claims cost comes under the target budget, the provider receives a surplus payment from the health plan. This annual process of reconciling claims cost to the target budget is called a settlement. In response to the AGO's civil investigative demands, health plans provided the annual

settlement statements and risk contracts for providers they pay on a global basis. This information enabled us to compare the size of the global budgets that health plans negotiate with different providers. The plans also provided us with health status scores that measure the demographics and health risk, or morbidity, of the populations cared for through global budgets. This way in comparing the size of the global budgets, we were able to adjust for differences in demographics and morbidity. So we were comparing budgets negotiated for similar populations. We identified wide variation in the global budgets negotiated from provider to provider that is not explained by the better paid providers caring for a sicker population. One factor in the negotiation of global budgets is the provider's historic level of spending. Negotiating global budgets based on how historically expensive a provider has been does not eliminate the wide variation of provider prices that the AGO has found. It also means that providers with smaller budgets have less to spend on the care of patients of similar health status. Many other elements of global payments are also negotiated and vary from provider to provider. For example, whether certain medical services are carved out of the global budget or the extent to which the provider receives infrastructure funding or whether there will be protections for the provider in the case of price

increases to other providers are all elements of global payments that are negotiated and vary from provider to provider. These complicate and varying components of risk contracts make it difficult to examine and compare how health plans are paying providers.

Three, total medical expenses. A third financial measure the AGO examined was total medical expenses, or TME. TME is the total dollar amount spent on the healthcare of a patient over a given period of time, usually examined per month. TME includes all of the expenses of caring for a health plan member regardless of the type of healthcare service. For example, TME includes physician visits, hospital services, pharmacy and laboratory costs, behavioral health and all other services. TME reflects both the volume of services used by each member utilization and the price paid for each service price. A lower TME will reflect lower utilization, lower price and/or lower mix of services. The TME of patients can be assigned to the provider group where the patient has his primary care provider. Health plans then compare the TME of patients at one provider group to the TME of patients of another provider group. They health status adjust the TME to account for differences in patient demographics and morbidity. This way, in comparing the TME of different provider

groups, a group that cares for a population with higher morbidity will not inaccurately appear as higher spending for that reason. The TME of members can also be analyzed by Massachusetts zip code. The data on total medical spending is aggregated by where the member resides. This way we can examine the total amount spend per member, by zip code, to see if there are geographic differences in spending. Again, we can health status adjust the TME so that if a zip code includes members who are older or with higher morbidity, it will not appear as having higher TME for that reason. Comparing TME by zip code also allows us to include the TME of patients who do not have a designated primary care provider and so are not assigned to a provider group for the purposes of comparing TME across provider groups. TME is the only financial measure that reports on all amounts paid for the healthcare of a member and it boils it down to one number that can be compared across provider groups or zip codes. Since TME is health status adjusted and reflects total cost, it's a good measure of efficiency. Health plans review this information and it is a well accepted measure of cost and efficiency that is regularly used in the industry. In my opinion, to evaluate the cost of healthcare, it's important to review total dollars spent in order to understand the total cost of the system. Evaluating a subset of expenses, for example

looking just claims cost without non-claims payments, cannot provide a complete picture of total healthcare cost.

In closing, I would like to highlight the importance of timely, accurate healthcare data so the market can measure and improve the quality and efficiency of healthcare and monitor the success of system reform. The AGO received a wealth of information from the major health insurers and a variety of providers in the state. I know it was a huge undertaking to pull all this information together. I commend the health plans and providers for providing this information. The AGO's analysis is valid and reasonably relies on the information produced by the health plans and the providers. Based on the AGO's analysis and my own experience, I believe there are additional steps we can take to improve access to timely and reliable healthcare information. For example, we can leverage the all payer claims database being developed by the Division of Healthcare Finance and Policy so that all healthcare stakeholders have access to this important repository of healthcare information. Thank you.

Martha Coakley

Thank you, Susan and Bela, and we have six suggestions that we have now for moving forward on cost containment that were related to our six key findings and then hopefully we'll have time for questions. First of all, we believe -- and I think you've heard this from several of the speakers this morning -- that it's crucial that we promote tiered and limited network products to increase value-based purchasing decisions, key to any market, particularly key to this market. Secondly, that we reduce healthcare price distortions through temporary, statutory restrictions, unless and until tiered and limited network products and commercial market transparency can improve market function. I think you heard Commissioner Murphy talk about that. I think you heard the Governor talk about that. I think you heard the legislators say that we need to move forward on it. We agree with that and part of the discussion going forward is exactly how we do that to accomplish the reduction of healthcare price distortions. Three, we need to encourage consumers to select a primary care provider you can assist consumers in coordinating care based on each consumer's needs and best interest. You've heard some of Susan's findings about the number of people in Massachusetts who are involved in PPOs do not

involve primary care physicians. I think that's an important discussion that we need to have not only with us, but with frankly the medical schools and the medical profession about how we go forward in this area. Fourth, we need to promote coordination of patient care through primary care providers by recognizing the need to improve funding of care coordination, including the infrastructure necessary to coordinate care and by giving providers timely access to relevant patient data, regardless of their size or payment methodology. Let me stress that. Our findings indicated that if you have that patient care coordination as a focal point, it does not matter, necessarily what the size is or the payment methodology is. It has to come first. So fifth, we need to consider steps to improve the use of the all payer claims database, the APCD, by first developing reports for providers in the public to guide development of patient care coordination and improvements and system accountability and two, increasing the standardization of claim level submissions by reducing differences in how payers report payment level information. That is something we can do, we should do. There's a cost involved in it obviously, but it's also crucial that we commit to doing this. We have the ability to do this. And sixth, that we develop appropriate regulations, solvency standards and oversight for providers who contract to

manage the risk of insured and self-insured populations. I think it's important to recognize, as we move forward, what we have experience with and what we don't. We have not, for awhile, dealt with handling risk in some of the organizations and so those all have to be carefully considered moving forward. It doesn't mean that we shouldn't move forward as quickly as we can, but I think our report indicates that we need to consider our findings and these recommendations to do this in a way that makes sense and will improve the delivery of quality healthcare in Massachusetts. So with that, I think we'd be happy to take questions if we have time.

Q

We received several questions. First, did your TME calculations include infrastructure support?

Susan Brown

Yes. The total medical expense figures were fully loaded.

Q

Does your analysis of providers under global payments look only at the cost for those patients under risk or did you combine those providers' efficiency for treating patients under all benefit designs? If not, what can you say about the provider's efficiency if it only represents a quarter of their commercial revenue?

Susan Brown

Let me answer the first part of that, which I think I understood and then I might have to clarify on the second. Total medical expenses for providers can only measure the total medical expenses of patients who have a primary care provider, which in this care are HMO patients. Since providers are only at risk for HMO patients, we were tracking all the TME information available for those HMO and preventive service patients, which for the most part included the risk bearing patients for those risk providers. Does that help answer the question? Did you understand the second part?

Bela Gorman

I think it’s difficult to aggregate all medical costs for a provider group across products because of the fact that the PPO product does not require primary care physician. So it’s actually impossible, unless we do an attribution method of some sort.

Q

I received two questions about global payments. Is it premature to make pronouncements about global payments at this point in time given that it’s just in its infancy and the other is do global payments hold value if the budgets are set at an appropriate or low level?

Martha Coakley

Let me answer the first one. We've heard that, that they're in their infancy, but that's one of the reasons why Susan specifically pointed to at least five years of several of them to look at records and that, at least, was a window. Not all of them have been in operation for five years, but enough of them were to see you didn't have that clustering to the low end of the scale and you did not see the savings that you might expect, given what the expectations are for global payments and I think the conclusion that we drew was that what we've said form the beginning, that global payments in and of themselves don't solve the problem. They clearly are part of the solution going forward. They make a lot of sense, but they will not solve the problem if we don't address the market dysfunction first because they will be baked in.

Q

Well then how do you propose dealing with market distortions as we move towards global payment legislation?

Martha Coakley

You let me take the tough ones then. Fair enough. That's part of what these hearings are about, frankly. I mean with our findings and the suggestions that we made at the end of the presentation -- it's all in the report -- we suggest several things, including looking at global payments and looking at tiered network. The basic idea is that if we cannot adjust and the market does not adjust, we're suggesting that we need temporary statutory restrictions on it, but we welcome the discussion around that because we recognize that this has been an effort by providers, by insurance companies, by other not for profits, by doctors, by the legislature, by the governor, by the commissioner and so that's part of what the discussion is. If we agree that the market is dysfunctional and we agree that we need to address it, we have that suggestion and we're happy to hear from everybody else as to what they think would make sense, but I think the governor was clear. I think the commissioner was clear and I think we believe that we have a lot of work to do around global payments and moving forward with accountable care organizations, but we've got to address that first. So

we’re happy to have all the suggestions everybody has as to how we at least mitigate to an acceptable level that market dysfunction.

Q

So a question actually on that. When you’ve referred to temporary statutory restrictions, are you referring to a floor and ceiling based on percentage of Medicare? If yes, are you proposing specific amounts?

Martha Coakley

No. The answer is no. That is our suggestion at this stage is that we need to consider some action and we’re not going farther than that today because I’d like to hear what other suggestions are, particularly from the folks who are going to be affected by it. I think we remain pretty clear; that is, we’ve made some changes. We made our report last year. The markets haven’t really seemed to adjust and we’re going to keep an open mind as to what we need to do to get rid of the market dysfunction and

we haven’t suggested anything specific yet, but we will certainly get there at some stage. So this is the time for everybody to be heard about what makes sense.

Q

Last question. How does the attorney general’s report help explain the wide disparity in financial health of hospitals in Massachusetts?

Susan Brown

Sure, I’m happy to take a stab. I think looking at both total medical expenses and prices, the reason we examine both of those measures is because it really is important when you’re looking at the market as a whole to look at both of those important metrics. When you look at different prices paid from insurers to providers, it helps give a window into how much providers with other hospitals or physicians have to spend on care, whether that’s salaries, whether that’s the capital investments, whether that’s the buildings, new technology, whatever it is.

So looking at those different prices paid helps to shine a light on how different providers are able to function in the market, what resources are really available to them.

Q

Sorry. This is actually the last question. Does Massachusetts need legislation to require patients who have a PPO to identify a PCP since that seems to be critical?

Martha Coakley

That is a very good question and I think that's something that I know we don't have an answer to that today, but part of what we want our report to do is raise exactly those kinds of questions. If we understand that going forward and having a system that works includes having primary care coordination, I think we've got to talk about ways that we provide incentives for the market to do that and I don't think we're prepared to go further than that. But I think we hope that people will be asking those questions going forward. Thank you.

Seena Perumal Carrington

Please join me in thanking, once again, the Attorney General's office for their analysis.

Martha Coakley

Thank you. Commissioner, could we have a round of applause for the terrific signers who are working very hard today?

Seena Perumal Carrington

There were a few questions that we weren't able to get to today, but over the course of the next few days I just want to remind you that the division and the Attorney General's Office will be sort of digging deeper into some of these analytical findings and so we will have an opportunity to address some of your questions then. So now we're turning to the public testimony

portion of our hearing and actually we only have one individual signed up, Virginia Mills from The Community Rehab Care.

Virginia Mills

Thank you and I'll only take a minute and I can't believe I'm the only one that has something to say. I'm a physical therapist by training. We specialize. I'm a small business owner who specializes in neuro rehab, taking care of people with traumatic brain injury and stroke mainly. I can tell you I'm very concerned about all of these discussions being a small business, downstream to a very specialty population that I provide services to in this one, big concern. That is that ACOs I think are going to be comprised of big players, the big groups, the big hospitals, the big physicians and it's the small providers, like myself, other physical therapists and private practice, we're the low cost providers. We really are the high quality, low cost providers. We are on the bottom of the fee schedule, let me tell you, but I feel like there's a whole group out there that could be swept away with the tide of healthcare reform in creating these large organizations, like ACOs, that would hopefully coordinate care. I can see how ACOs would work

upstream, in the Q care side of things, but the difference between what you do in a Q care before you get the person home and then after the person is home are two different sides of healthcare. People downstream do not do what people upstream do very well. People upstream do not do what we do very well downstream. So I have a great concern about this because it's the downstream, chronic people who are very expensive to this state and if not well managed, do end up costing us more and I just don't know how that's all going to come together. So it's a great concern of mine and I'm not the only one who thinks it. I belong to networks of people who think the same thing, so I just wanted to get it out on the record. Thank you.

Seena Perumal Carrington

Thank you, Virginia. If there are no other comments, then I want to thank all of you for attending today's hearings. We obviously can't make progress in reducing healthcare costs without a commitment by all parties to understand and address the issue and I appreciate your patience and willingness to sit through today's proceedings and I hope that you will join us for the next three days. I just want to quickly highlight some of

the key discussion points that we heard today. Governor Patrick, Chairman Moore, Chairman Walsh and Chairman Sanchez and the other state officials reminded us of the extraordinary leadership and commitment we have from both the administration and the legislature to tackle difficult challenges and identify strategies that will lead to lasting, meaningful change in the Massachusetts healthcare system. The division's consultants summarized some of the key findings from our analysis. That healthcare spending per member grew 5% from 2007-2008, while per capita GDP only grew 2% during that same time period. Interestingly, price, not utilization, was the single, most important factor driving the rising private healthcare spending, while it was just the opposite for public payers in which greater service use led to increased spending. The remarks from the division of insurance and the results of the Attorney General's Office echoed some of the agencies findings. For example, one area of particular concern and opportunity is the wide variation in prices paid by private health plans for the same service at different providers. I only raise that specific challenge because that will be the theme of tomorrow's discussion. The goal of today was really to set the stage for the conversations over the next three days. In order to develop effective policy solutions, it's obviously essential that we

better understanding the data on cost growth in the state and also the impact of inaction. On Tuesday, Wednesday and Thursday, we're going to discuss specific challenges confronting the healthcare delivery system, hear about progress made to date by public and private efforts and then explore opportunities for further innovation. We'll reconvene tomorrow, then, at 9:00 AM in this room. Thank you all for attending.

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